MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-21

03990

CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH:
County Harford
City or town Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 35 E. Bel Air ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Harford
City or town Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
Street No. 35 E. Bel Air ave.
(If rural, give LOCATION)
2.(a) If veteran, name war None

3.(a) FULL NAME George Bristow Adams

3.(b) Social Security Number None

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of ~~husband or~~ wife: Myrtle Carr
6.(c) If alive, give age .... years
7. Birth date of deceased (mo., day, yr.): June 28 - 1894

8. AGE: Years 50 Months 10 Days ..... If less than one day ..... hrs. ..... min.

9. Birthplace: Aberdeen (Town, county, and state)
10. Usual occupation: Merchant
11. Industry or business

FATHER
12. Name: William N. Adams
13. Birthplace: Havre de Grace

MOTHER
14. Maiden name: Emma A. Bristow
15. Birthplace: Havre de Grace

16. Informant: J. Victor Adams
Address: 477 W. Bel Air Ave. Aberdeen

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 11 - 1945 (month) (day) (year)
Cemetery ~~or crematory~~: Baker
Location: Aberdeen

18. Funeral director: Henry Tarring & Sons
Address: Aberdeen

19. Apr. 10 1945 (Date rec'd by registrar) Nellie H. Riley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1945, at 3:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from only visit date of death 19.... to .... 19....
and that I last saw h im alive on April 8th 1945

Cause	DURATION
Immediate cause of death: Cerebral hemorrhage	1 hr.
Due to: Arteriosclerosis Hypertension	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings of operations .... Date of op. ....
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide .... Date of ....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury .... Injured at work?

23. SIGNATURE Thos. P. Thompson M. D. or other
Address Aberdeen Md Date signed Ap. 9/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

03991

Reg. Dist. No. 185

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Harford

City or town Havre de Grace (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Harford Memorial Hospital

How long in hospital or institution? ~~3 mos.~~ 10 months

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Delaware County —

City or town Milford (If outside city or town limits, write RURAL and give nearest town)

Street No. — (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Anderson

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	S

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 7, 1945

8. AGE: Years	Months	Days	If less than one day
			hrs. 10 min.

9. Birthplace Havre de Grace, Harford Co., Md. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Francis Alexander Anderson

13. Birthplace Salisbury Md.

MOTHER 14. Maiden name Ruth Ann Denny

15. Birthplace Milford, Del.

16. Informant Ruth Ann Anderson - Mother

Address Salisbury, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/10/45 (month) (day) (year)

Cemetery or crematory County Cem.

Location Havre de Grace

18. Funeral director Pennington & Son

Address Havre de Grace

19. Apr. 10 1945 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-9 1945 at 1235 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-9-45 1945 to 4-9- 1945 and that I last saw h alive on 4-9- 1945

Immediate cause of death	DURATION
prematurity	
Due to Inevitable abortion	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. J. Simon M. D. or other

Address Havre De Grace Date signed 4-10 45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

63992

Reg. Diat. No. 182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Harford
City or town Forest Hill
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Harford
City or town Forest Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Nannie M. Bailey

3.(b) Social Security Number

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Erastus J. Bailey
8.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Oct 26, 1869
8. AGE: Years 75 | Months 5 | Days 23 | If less than one day ... hrs. ... min.
9. Birthplace: Bland Va.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Edw a Davis
13. Birthplace: Va
MOTHER 14. Maiden name: Syrilda Dills
15. Birthplace: Va
16. Informant: Mrs Merrill Gratton
Address: Forest Hill, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 22 1945 (month) (day) (year)
Cemetery or crematory: Wm Watters Mem.
Location: Cooptown, Md.
18. Funeral director: Martin G. Kurtz
Address: Jarrettsville, Md.
19. 4-20- 1945 (Date rec'd by registrar) Priscilla Forwood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19, 1945, at 12 P M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 1 1945 to April 19 1945
and that I last saw h.e.r. alive on April 18 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 1/2 da
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Willard P. Hudson M. D. or other
Address Forest Hill, Md Date signed 4/19/45

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93)

03393

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH:
County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Harford Memorial Hospital
How long in hospital or institution? 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. 727 Ontario St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Bertha Barnes

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Mar. 17, 1875

8. AGE: Years 70 | Months 1 | Days 2 | If less than one day ..... hrs. ..... min.

9. Birthplace Havre de Grace Harford, Md.
(Town, county, and state)

10. Usual occupation None

11. Industry or business

MOTHER FATHER
12. Name John G. Barnes
13. Birthplace Md.

MOTHER
14. Maiden name Mary Anne Wood.
15. Birthplace Md.

18. Informant Miss Bertha Barnes
Address 727 Ontario St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/22/45 (month) (day) (year)
Cemetery or crematory Angel Hill
Location Havre de Grace
18. Funeral director Pennington & Son
Address Havre de Grace

19. Apr. 21 1945 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 1945 at 5:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-26 1945, to 4-19 1945 and that I last saw her alive on 4-19 1945

	DURATION
Immediate cause of death: Cerebro-vascular Accident	11 days
Due to: Hypertensive Cardiovascular Disease	?
Due to: Arteriosclerotic Heart Disease	?
Other conditions: Coronary Occlusion	34 days

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Charles H. Tyson M.D.
Address Harford Memorial Hosp. Havre de Grace, Md. M. D. or other
Date signed 4-19-45

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03994

CERTIFICATE OF DEATH

Reg. Dist. No. 183

1. PLACE OF DEATH:
County: Harford
City or town: Federal Hill (If outside city or town limits, write RURAL and give nearest town) Locks RD
How long in above place of death? 1 year 2 months
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md County: Harford
City or town: Federal Hill (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mary Caroline Boyer

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col	widow

6.(b) Name of husband or wife: Joseph Boyer
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan - 1863

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
82	2			

9. Birthplace: Balto Co Md (Town, county, and state)
10. Usual occupation: Mill Worker
11. Industry or business: Woodbery Mills, Retired

MOTHER FATHER
12. Name: Not Known
13. Birthplace: Not Known

MOTHER
14. Maiden name: — Evans
15. Birthplace: Not Known

16. Informant: Ida Robinson
Address: Rocks Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr 11-45 (month) (day) (year)
Cemetery or crematory: St James Cem.
Location: Federal Hill Harford Co
18. Funeral director: Marion E Hurtz
Address: Jarrettsville Md.

19. Apr. 11 1945 Thomas R. Brown
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 7, 1945 at 9 30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1, 1945 to April 5, 1945 and that I last saw h.. alive on April 5, 1945

Immediate cause of death: Heart failure — DURATION: 7

Due to: Hypertension

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Charles A. [illegible] M. D. or Coroner
Address: Jarrettsville, Md Date signed: 4-8-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03995

Reg. Dist. No. 183

1. PLACE OF DEATH:
County: Harford
City or town: Taylor
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Harford
City or town: Taylor
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Harold F Bryant

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Divorced

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov 12 1881

8. AGE: Years: 63 Months: 5 Days: 5 If less than one day: ..... hrs. ..... min.

9. Birthplace: Atlanta Georgia
(Town, county, and state)

10. Usual occupation: U S Goverment Employe

11. Industry or business: Welfare

FATHER
12. Name: John Cook
13. Birthplace: not known

MOTHER
14. Maiden name: Jennie A Caldwell
15. Birthplace: Catawba Co N.C.

16. Informant: Mary C Senff.
Address: Mokston Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 19 45 (month) (day) (year)
Cemetery or crematory: Ebenezer
Location: near Taylor Harford Co Md

18. Funeral director: Martin & Kentz.
Address: Jarrettsville Md.

19. Apr 19 1945 (Date rec'd by registrar) Thomas R. Brown Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr 17 1945, at 9 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Fall 1944, to Apr 1945
and that I last saw her alive on Apr 16 1945

Immediate cause of death	DURATION
Pulmonary Oedema	
Due to: Carcinoma of Uterus Metastasis to Sternum	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: P B Hopkins M. D. or other
Address: Bel Air Md Date signed 4/19/45

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03996

Reg. Dist. No. 182

1. PLACE OF DEATH:
County Harford
City or town Bel Air
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Harford
City or town Bel Air
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Charles Joseph Dick

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife Catherine McCourtney
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 1 1872

8. AGE: Years	Months	Days	If less than one day
73	8	6	hrs. min.

9. Birthplace Mill Green Harford Co Md (Town, county, and state)
10. Usual occupation Farmer
11. Industry or business Retired
FATHER 12. Name Wm L Dick
13. Birthplace Harford Co Md
MOTHER 14. Maiden name Mary Robinson
15. Birthplace Harford Co Md
16. Informant Mrs Mamie Stambaugh
Address 3142 Remington Ave Balto
17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 10 -45 (month) (day) (year)
Cemetery or crematory Emory
Location Street Md
18. Funeral director Martin L Kurtz
Address Jarrettsville Md.
19. 4-7 1946 Priscilla Fawwood (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1946, at 5.30 AM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1945 to Apr 1945
and that I last saw him alive on Apr 6 1945
Immediate cause of death Paralysis

	DURATION
Due to Arteriosclerosis & Hypertension	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE P M Hopkins M. D. or other
Address Bel Air Md Date signed 4/7/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 836

CERTIFICATE OF DEATH

03997 T

Reg. Dist. No. 18

1. PLACE OF DEATH:
County: Harford
City or town: Street (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Harford
City or town: Street (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Edward John Dutton

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	C	Married

6.(b) Name of husband or wife: Nellie I Dutton
6.(c) If alive, give age: 39 years

7. Birth date of deceased (mo., day, yr.): May 11 - 1894

8. AGE: Years: 50 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Harford Co, Md
(Town, county, and state)

10. Usual occupation: Labor

11. Industry or business

FATHER
12. Name: W M R Dutton
13. Birthplace: Md

MOTHER
14. Maiden name: Ruth A Talbott
15. Birthplace: Md

18. Informant: Nellie I Dutton
Address: Street, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 3/45 (month) (day) (year)
Cemetery or crematory: Clark's Chapel
Location: Gibson, Harford Co
18. Funeral director: Deaver & Baker
Address: Belair Md

19. 5/2 (Date rec'd by registrar) 19 45 Priscilla Forward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 30 19 45 at 5 15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 30 19 45 to April 30 19 45 and that I last saw h.l.m. alive on April 30 19 45

Immediate cause of death	DURATION
Cerebral thrombosis	6 hrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Gerald E Palmer M.D.
M. D. or other
Address: Belair, Md. Date signed: 5/1/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03998

Reg. Dist. No. 184

1. PLACE OF DEATH

County Harford

City or town Darlington Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Harford

City or town Darlington Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war No

3.(a) FULL NAME Elsie Lee Edwards

3.(b) Social Security Number No

4. Sex: Female | 5. Color or race: White | 6.(a) Single, married, ~~widowed, or divorced~~: Married

6.(b) Name of husband or wife: Felix Edwards

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 19, 1904

8. AGE: Years: 42 | Months: 5 | Days: 25 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Alleghany Co., N. C.
(Town, county, and state)

10. Usual occupation: Housework at Home

11. Industry or business: Farm Crops

FATHER — 12. Name: T. R. Crouse

FATHER — 13. Birthplace: Alleghany Co., N. C.

MOTHER — 14. Maiden name: Lula Cox

MOTHER — 15. Birthplace: Alleghany Co. N. C.

16. Informant: Felix Edwards

Address: Darlington Md R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 16 1945 (month) (day) (year)

Cemetery or crematory: Zion Cem.

Location: Alleghany Co. N. C.

18. Funeral director: H. B. Bailey

Address: Darlington, Md.

19. April 14 46 (Date rec'd by registrar) M. A. Kirk Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 14 1945, at 4 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1943 to April 14 1945 and that I last saw h[illegible] alive on April 14 1945

Immediate cause of death	DURATION
Pulmonary hemorrhage	sudden
Due to: Pulmonary tuberculosis	2 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Ralph Harley M.D.
M. D. or other

Address Churchville Md Date signed April 14

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (182-0)

CERTIFICATE OF DEATH

03999

Reg. Dist. No. 182

1. PLACE OF DEATH:

County: Harford

City or town: Bel Air

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Two days.

Hospital, Institution, or street address where death occurred: Fountain Green Hospital

How long in hospital or institution? Two days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Edgewood

(If outside city or town limits, write RURAL and give nearest town)

Street No.: R# I

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Richard John Evans

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Infant

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 23, 1945

8. AGE: Years | Months | Days: 2 | If less than one day: hrs. min.

9. Birthplace: Bel Air, Harford Co., Maryland (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER

12. Name: Lee Bert Evans

13. Birthplace: Alleghany Co., North Carolina

MOTHER

14. Maiden name: Ruby Ileen Cromas

15. Birthplace: Sparta, North Carolina

16. Informant: Lee Bert Evans

Address: Edgewood, RD

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 26, 1945 (month) (day) (year)

Cemetery or crematory: St. Mary's Church

Location: Edgewood, Maryland

18. Funeral director: Dean and Foster

Address: Bel Air, Maryland

19. 4-25-1945 (Date rec'd by registrar) Priscilla Steward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 25, 1945 at 9:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 23 1945 to April 25 1945 and that I last saw him alive on April 25 - 1945

Immediate cause of death	DURATION
Unknown probably a Cerebral hemorrhage	
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Willard P. Hudson M. D. or other

Address: Forest Hill Md. Date signed: 4/25/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04000

Reg. Dist. No. 182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Harford
City or town: Bel Air
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 28 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Harford
City or town: Bel Air Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Katherine R Fulford

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	W

6.(b) Name of husband or wife: Frank Hays Fulford
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 13, 1887

8. AGE: Years	Months	Days	If less than one day
58			..... hrs. ..... min.

9. Birthplace: Baltimore (Town, county, and state)
10. Usual occupation: House Duties
11. Industry or business
12. FATHER — Name: Col Wm Robertson
13. FATHER — Birthplace: Hampton Va
14. MOTHER — Maiden name: Valiant
15. MOTHER — Birthplace: Balto., Md
16. Informant: Frank H Fulford
Address: Bel Air, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 23/45 (month) (day) (year)
Cemetery or crematory: Rock Spring
Location: Forest Hill
18. Funeral director: Deaner & Foster
Address: Belair Md
19. 4-23 1945 (Date rec'd by registrar) Priscilla Foxwood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 20 1945, at 7^m M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 18th 1945 to April 20th 1945 and that I last saw her alive on April 20th 1945

	DURATION
Immediate cause of death: Cerebral hemorrhage	62 hours
Due to:	
Due to:	
Other conditions: Hypertension	?

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: A. F. Van Bibber, M.D. (M.D. or other)
Address: Bel Air, Md April 21, 1945 (Date signed)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04001

Reg. Dist. No. 181

1. PLACE OF DEATH:

County: Harford

City or town: Aberdeen

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs.

Hospital, Institution, or street address where death occurred: 41 Mt Royal Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Aberdeen

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 41 Mt Royal Ave.,

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Harry Coleman Holloway

3.(b) Social Security Number: None

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Anna Pist

6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): March 26 1868

8. AGE: Years: 77 Months: Days: 12 If less than one day: hrs. min.

9. Birthplace: Perryman (Town, county, and state)

10. Usual occupation: Farmer & Canner

11. Industry or business: Retired

FATHER 12. Name: Charles C. Holloway

13. Birthplace: Perryman

MOTHER 14. Maiden name: Katherine Gallagher

15. Birthplace: Perryman

16. Informant: Mrs. Anna R. Holloway

Address: 41 Mt. Royal Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 10 1945 (month) (day) (year)

Cemetery or crematory: Presentia

Location: Perryman

18. Funeral director: Henry Taxing & Sons

Address: Aberdeen, Md.

19. Apr. 10 1945 (Date rec'd by registrar) Nellie L. Riley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 8th 1945, at 1.05A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 16 1945 to April 8 1945 and that I last saw h.. alive on April 8th 1945

Immediate cause of death: Chronic Myo-Carditis with scattered atheroma accompanied by Angina Pectoris.

DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Howard D. Holloway M. D. or other

Address: Perryman, Md. Date signed: Apr. 6 '45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

CERTIFICATE OF DEATH

04002

Reg. Diat. No. 184

1. PLACE OF DEATH:
County: Harford
City or town: Whiteford
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Whiteford
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mary Jo Jones

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	✓

6.(b) Name of husband or wife: ✓
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec 29 1935

8. AGE: Years 9 | Months 3 | Days 29 | If less than one day ..... hrs. ..... min.

9. Birthplace: Harford Co, Md.
(Town, county, and state)

10. Usual occupation: Student

11. Industry or business

FATHER
12. Name: George B. Jones
13. Birthplace: Harford Co, Md.

MOTHER
14. Maiden name: Reta Allison
15. Birthplace: Harford Co, Md.

16. Informant: George B. Jones
Address: Whiteford, Md.

17. Burial (Burial, cremation, or removal (which?)) Date thereof May 1 1945 (month) (day) (year)
Cemetery or crematory: Slate Ridge
Location: Delta, Pa.

18. Funeral director: Hufft P. Harbeno.
Address: Delta, Pa.

19. May 1 19 45 (Date rec'd by registrar) Carl E. Knoop Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 28 19 45 at 4 30 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19 ..... to ..... 19 .....
and that I last saw h... alive on ..... 19 .....

Immediate cause of death	DURATION
Accidental Drowning	½ hour
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 4/28/45
Where did injury occur? Whiteford Harford Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Quarry
Means of injury: Fell into quary Injured at work? no

23. SIGNATURE: Gerald C. Palmer M.D.
Deputy medical Examiner
Harford County M. D. or other
Address: Delta, Pa. Date signed 4/28/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

04003

Reg. Dist. No. 185

1. PLACE OF DEATH:
County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 yrs
Hospital, institution, or street address where death occurred: 717 Ontario St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. 666 Ontario St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Mary Eldora Kalb

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Conard H. Kalb
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 17, 1868

8. AGE: Years 76 | Months 10 | Days 10 | If less than one day: hrs. min.

9. Birthplace: Texas Md.
(Town, county, and state)

10. Usual occupation: Home Duties

11. Industry or business: Self

FATHER
12. Name: Benjamin Phillips
13. Birthplace: Pa

MOTHER
14. Maiden name: Sarah C. Williams
15. Birthplace: Md.

16. Informant: Mr. George L. Kalb
Address: 666 Ontario St. Havre de Grace

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 30, 1945 (month) (day) (year)
Cemetery or crematory: West Nottingham
Location: Cecil Co. Md.

18. Funeral director: R. Madison Mitchell
Address: Havre de Grace Md.

19. Apr. 30 1945 (Date rec'd by registrar) C. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr. 27 1945 at 9 55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to Apr 27 1945
and that I last saw h[illegible] alive on Apr. 27 1945

Immediate cause of death	DURATION
Acute Dilatation, Hypertension,	
Due to: Cerebral Hemorrhage	
Due to: Chronic Diffuse Nephritis	
Due to:	
Other conditions: Terminal	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Charles J. Foley M.D. M. D. or other
Address: Havre de Grace Date signed: 4/29/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18(a)

CERTIFICATE OF DEATH

04004 . 7 180

Reg. Dist. No.

P

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Harford
City or town: Bradshaw
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 Weeks
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Harford
City or town: Bradshaw
(If outside city or town limits, write RURAL and give nearest town)
Street No.: New Philadelphia Rd
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Antonia Klein

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: John Klein
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): October 15-1868

8. AGE: Years	Months	Days	If less than one day
76	6	7	..... hrs. ..... min.

9. Birthplace: Germany (Town, county, and state)
10. Usual occupation:
11. Industry or business:
FATHER 12. Name: Melchior Kerst
13. Birthplace: Germany
MOTHER 14. Maiden name: Mary Beisel
15. Birthplace: Germany
16. Informant: Wm G. Klein
Address: 1601 N. Patterson St
17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/25/45 (month) (day) (year)
Cemetery or crematory: New Cathedral
Location: Baltimore, Md
18. Funeral director: F. S. Kappert & Son
Address: 300 Eutaw Place
19. 4/26 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 25th 1945 at 10 45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19 45 to April 19 45 and that I last saw h.. alive on April 25 19 45

Immediate cause of death: Cerebral Haemorrhage — DURATION: 2 wks
Due to: Hypertension — 3
Due to:
Other conditions: Cardio Vascular Renal — 3
(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Wm Bonelli M. D. or other
Address: 1113 Frederick Rd Date signed 8/14/45

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04005

CERTIFICATE OF DEATH

Reg. Dist. No. 195-

1. PLACE OF DEATH:
County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 yrs.
Hospital, institution, or street address where death occurred: St. Francis Villa
How long in hospital or institution? 8 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. Commerce & Market
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Sr. Mary Hildebrita Winifred Lannon

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 9-1872

8. AGE:

Years	Months	Days	If less than one day
73	1	29	..... hrs. ..... min.

8. Birthplace U. S. A.
(Town, county, and state)
10. Usual occupation Nurse
11. Industry or business —
FATHER 12. Name Thomas Lannon
13. Birthplace Ireland
MOTHER 14. Maiden name Mary ? Lannon
15. Birthplace Ireland
16. Informant Hosp. Records
Address Commerce & Market
17. Burial Date thereof 4/9/45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Holy Redeemer
Location Baltimore, Md.
18. Funeral director Pennington & Son
Address Havre de Grace
19. Apr. 9. 1945 A. L. Lewis M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1945 at 6 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1944 to April 7 1945
and that I last saw h alive on April 7 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	
Due to	
Due to Cachexia	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Charles J. Foley M.D.
M. D. or other
Address Havre de Grace Date signed 4/9/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

CITIES CORPORATE LIMITS ONLY

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 04006, 18 S-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County: Harford

City or town: Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yrs.

Hospital, Institution, or street address where death occurred: St. Francis Villa Havre de Grace

How long in hospital or institution? 6 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Commerce & Market

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

Sr. M. Petronella Emma Maloney

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): March 6-1869

8. AGE: Years: 76 | Months: 1 | Days: 24 | If less than one day: hrs. min.

9. Birthplace: Delaware City Del. (Town, county, and state)

10. Usual occupation: Teacher

11. Industry or business: —

FATHER — 12. Name: John Maloney

FATHER — 13. Birthplace: Ireland

MOTHER — 14. Maiden name: Alice Keane

MOTHER — 15. Birthplace: Ireland

16. Informant: Hosp. Records

Address: Havre de Grace

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5/2/45 (month) (day) (year)

Cemetery or crematory: Holy Redeemer

Location: Baltimore, Md.

18. Funeral director: Pennington & Son

Address: Havre de Grace, Md.

19. May 1 1945 (Date rec'd by registrar) C. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4/30/45 19 at 2:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19 47, to April 30 19 45

and that I last saw h... alive on April 30 19 45

Immediate cause of death	DURATION
Uremia Edema	
Hypertension	
Due to: Arterial Hemorrhage	
Due to: Toxemia	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Havre de Grace Md. Date signed: 5/4/45

WITHIN CORPORATE LIMITS of

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04007

Reg. Dist. No. 185

1. PLACE OF DEATH:
County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 Week.
Hospital, institution, or street address where death occurred: 314 So. Union Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED
(For newborn infants, give residence of mother)
State: Md. County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. 502 Erie St
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME ~~William~~ Wilson Jacob Reisinger

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife —
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec. 27, 1918

8. AGE: Years 26 | Months 3 | Days 12 | If less than one day ... hrs. ... min.

9. Birthplace Harford Co (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business
FATHER 12. Name John C Reisinger
13. Birthplace Md.
MOTHER 14. Maiden name Sarah M. Hill
15. Birthplace Md.
16. Informant Mr. John C. Reisinger
Address Havre de Grace, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 6, 1945 (month) (day) (year)
Cemetery or crematory Wesleyan Chapel
Location Harford Co. Md.
18. Funeral director P. Madison Mitchell
Address Havre de Grace, Md.
19. April 6 19 45 A. F. Lewis M. D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 19 45, at 6A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ..., to ... 19 ...
and that I last saw h... alive on ... 19 ...

	DURATION
Immediate cause of death: Diabetes	3 days
Due to:	
Due to:	
Other conditions: Congenital heart disease	—

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Gerald C Palmer M.D.
Deputy medical Examiner Harford County M. D. or other
Address Bel Air, Md. Date signed 4/4/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

04008

CERTIFICATE OF DEATH

Reg. Diat. No. 182

1. PLACE OF DEATH:
County Harford
City or town Near Forest Hill Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Harford
City or town Near Forest Hill Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Thomas Allen Salyers

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jany 9/45

8. AGE: Years | Months 3 | Days | If less than one day hrs. min.

9. Birthplace Fountain Green (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Ernest Salyers
13. Birthplace Va

MOTHER 14. Maiden name Beulah Taylor
15. Birthplace Va

16. Informant Mrs Ernest A Salyers
Address Forest Hill Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 14/45 (month) (day) (year)
Cemetery or crematory Mt Zion
Location Fountain Green
18. Funeral director Dewey Foster
Address Bel Air Md

19. 4.13.45 (Date rec'd by registrar) Priscilla Lowood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 19 45, at 3 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Malnutrition	3 mo
Due to Prematurity at 7 mo	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Gerald C. Palmer M.D
Deputy Medical Examiner
Harford County
M. D. or other
Address Bel Air, Md. Date signed 4/13/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (42)

CERTIFICATE OF DEATH

04009

Reg. Dist. No. 185

1. PLACE OF DEATH:
County: Harford
City or town: Havred Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 yrs
Hospital, institution, or street address where death occurred: 820 Ontario St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. 820 Ontario St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Norman Munson Sentman

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Mary E. Sentman
6.(c) If alive, give age: —

7. Birth date of deceased (mo., day, yr.): Jan. 4, 1858

8. AGE: Years	Months	Days	If less than one day
87	3	8	— hrs. — min.

9. Birthplace: Cecil Co. Md. (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: Carpenter

FATHER
12. Name: Ellis S. Sentman
13. Birthplace: Penn.

MOTHER
14. Maiden name: Sophia Jackson
15. Birthplace: Md.

16. Informant: Mrs. Harry W. Sentman
Address: Havre de Grace, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 15 1945 (month) (day) (year)
Cemetery or crematory: Principio Meth. Ch. Yd.
Location: Cecil Co. Md.

18. Funeral director: R. Madison Mitchell
Address: Havre de Grace, Md.

19. Apr. 13 1945 (Date rec'd by registrar) C. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 17 1945 at 9 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 2 1944 to Apr. 17 1945
and that I last saw h— alive on Apr. 11, 1945

	DURATION
Immediate cause of death: Coronary accident	
Due to: Hypertension	
Due to: Chronic Nephritis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury. Injured at work?

23. SIGNATURE: C. L. Lewis M.D. M. D. or other
Address: Havre de Grace, Md. Date signed 4-13-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M)

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CITIES INCORPORATED LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

04010

Reg. Dist. No. 185

1. PLACE OF DEATH:

County: Harford

City or town: Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 hrs

Hospital, Institution, or street address where death occurred: Harford Memorial Hospital

How long in hospital or institution? 6 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Harford.

City or town: Rural Harve de Grace RFD #2.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Violet Singleton. (Mrs.)

3.(b) Social Security Number –

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Married.

6.(b) Name of husband or wife: Albert Singleton

6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): Feb. 9 1906

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
39	2	0	–	

9. Birthplace: Harford, Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own home.

FATHER 12. Name: William McComas

13. Birthplace: Harford Co., Md.

MOTHER 14. Maiden name: Sarah Weaver

15. Birthplace: Harford Co., Md.

16. Informant: Albert Singleton

Address: Havre de Grace, Md., RFD #2

17. Burial (Burial, cremation, or removal. Which?) Date thereof apr. 13, 1945 (month) (day) (year)

Cemetery or crematory: Dublin Meth Ch. Yd.

Location: Harford Co. Md.

18. Funeral director: R. Madison Mitchell

Address: Havre de Grace Md.

19. apr. 13 1945 (Date rec'd by registrar) C. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4-10- 1945 at 6 13/A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-10- 1945, to 4-10- 1945 and that I last saw h[illegible]ive on 4-10 1945

Immediate cause of death	DURATION
Hypex Pyrexia	4 hrs
Due to: Basal cerebral hemorrhage.	12 hrs
Due to: Hypertensive Cardio vascular disease	6 mo
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Charles H Ligon M.D. M. D. or other

Address: Harford Memorial Hosp Havre de Grace Md Date signed 4-10-45

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

04011

Reg. Dist. No. 185

1. PLACE OF DEATH:
County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Harford Memorial Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State New York County
City or town New York
(If outside city or town limits, write RURAL and give nearest town)
Street No. 330 East 11th St
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME George Stephens

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	M.

6.(b) Name of husband or wife Florence Stephens
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 10/28/1901

8. AGE: Years	Months	Days	If less than one day
43	5	29	..... hrs. ..... min.

9. Birthplace Rumania
(Town, county, and state)
10. Usual occupation Painter
11. Industry or business
FATHER 12. Name Christ Stephens
13. Birthplace Romania
MOTHER 14. Maiden name Helen [illegible]
15. Birthplace Romania
16. Informant Nicholas Taranu - Cousin
Address Lafayette Hotel - Havre de Grace
17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-1-45 (month) (day) (year)
Cemetery or crematory Rosemount Fresh Pond
Location Baltimore, Md. New York
18. Funeral director Pennington & Son
Address Havre de Grace, Md.
19. 4-28 1945 A. L. Lewis M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27 1945 at 3:25 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Burns, third degree	3 hrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 4/27/45
Where did injury occur? Aiken (City or town) Cecil (County) Md. (State)
Injured at home, farm, industry, public place (where?) B to O R R Bridge
Means of injury Electric Injured at work? yes

23. SIGNATURE Gerald C. Palmer M.D.
Deputy Medical Examiner
Harford County
M. D. or other
Address Aiken, Md. Date signed 4/27/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M)

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04013

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH:
County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Harford Memorial Hospital
How long in hospital or Institution? 1 hr

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. 800 Conestio St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Dorothy Mildred Walker

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: James Earl Walker
6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): Mar. 3, 1905

8. AGE:

Years	Months	Days	If less than one day
40	1	1	hrs. min.

9. Birthplace: Marshalton Del. (Town, county, and state)
10. Usual occupation: House Wife
11. Industry or business:
FATHER 12. Name: John E. Whyte
13. Birthplace: Scotland
MOTHER 14. Maiden name: Catherine E. Girling
15. Birthplace: England
16. Informant: Mr. James Earl Walker
Address: 800 Conestio St. City
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 7 1945 (month) (day) (year)
Cemetery or crematory: Angel Hill Cem.
Location: Havre de Grace Md.
18. Funeral director: R. Madison Mitchell
Address: Havre de Grace, Md.
19. April 6 1945 C. L. Lewis M. D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 4 1945, at 8:45 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1945 to Apr 4 1945 and that I last saw her alive on Apr. 4 1945

Immediate cause of death	DURATION
Streptococcus Throat Septicemia	
Due to Acute Endocarditis	
Due to Tonsilitis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Chas. J. Foley M.D. M. D. or other
Address: Havre de Grace Md. Date signed: 4/6/45

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04012

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH:

County Harford

City or town Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 39 yrs

Hospital, institution, or street address where death occurred: Harford Memorial Hospital

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford

City or town Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

Street No. 123 N. Union Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME LOUIS WEBER

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	Divorced

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 15, 1906

8. AGE: Years	Months	Days	If less than one day
39	0	4	..... hrs. ..... min.

9. Birthplace Havre de Grace, Harford, Md.

(Town, county, and state)

10. Usual occupation Chauffer.

11. Industry or business

FATHER 12. Name Walter Weber.

13. Birthplace Md.

MOTHER 14. Maiden name ~~Mother~~ Wilhelmina Taylor

15. Birthplace Md.

16. Informant Mrs Lydia Pilcher (sister)

Address Havre de Grace, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/22/45 (month) (day) (year)

Cemetery or crematory Angel Hill

Location Havre de Grace

18. Funeral director Pennington & Son

Address Havre de Grace

19. Apr. 21 19 45 C. L. Lewis M.D. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 19 45, at 5 15 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19 ..... to — 19 .....

and that I last saw h ..... alive on ..... 19 .....

Immediate cause of death	DURATION
Acute cardiac dilatation	?
Due to Bronchopneumonia	?
Due to	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Negative

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Gerald C Palmer M.D. Deputy Medical Examiner Harford County

Address 240 Main, Bel Air, Md. M. D. or other

Date signed 4/19/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15